CVCB/SAEP/06/04

SEXUAL ASSAULT EXAMINATION CERTIFICATE

Facility Name: _____

Facility Address: _____

Date and Time of Examination: _____

County and State Where Assault Occurred: _____

Date and Time of Assault: _____

PATIENT INFORMATION

Female _____ Male _____

Date of Birth: _____ Age: _____

Social Security Number _____

Patient Number _____

Does the patient have any health insurance coverage (public or private)?

YES _____ NO _____

PHYSICIAN/S.A.N.E. CERTIFICATION

I hereby certify that a forensic sexual assault examination was performed by me upon the above-named patient on the _____ day of _____, 20_____.

Physician (Print Name)	S.A.N.E. (Print Name)
License Number	**OR** License Number
Signature	Signature

CERTIFICATION OF NOTIFICATION TO LAW ENFORCEMENT

I hereby certify that _____ (Name and Title) with _____ (Law Enforcement Agency and Telephone Number)

was notified of the above-reported sexual assault on the _____ day of _____, 20_____.

(Facility Employee's Signature)	(Facility Employee's Printed Name and Title)

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I, _____ (Name of Patient or Minor Patient's Parent/Guardian), hereby authorize the facility and physician/S.A.N.E. named above to release the Sexual Assault Examination Certificate, itemized billing statement(s), and substantiating Physician/SANE notes for the forensic sexual assault examination/child sexual abuse examination to the Sexual Assault Examination Program for the purpose of enabling the above-named facility, as well as the examining physician or S.A.N .E., to present a claim for payment of the forensic examination expenses.

(Signature of Patient or Minor Patient's Parent/Guardian)	(Date)

NOTICE TO PATIENT OR PARENT/GUARDIAN:

You should <u>not</u> receive any billing statements for the forensic services rendered on this date. However, you may be billed for non-sexual assault examination emergency services. If you do, please contact the Crime Victims Compensation Board at (502) 573-2290 or toll free at 1-800-469-2120.

Send this completed form with itemized billing statement(s) to:

Sexual Assault Examination Program
c/o Crime Victims Compensation Board
130 Brighton Park Blvd.
Frankfort, KY 40601-3417

Billing Questions?
Contact CVCB at
(502) 573-2290 or
CVCB@ky.gov